

A SHORT GUIDE TO WAITING LIST MANAGEMENT

This booklet has been produced and published by CREST (the Clinical Resource Efficiency Support Team). CREST is a small committee of doctors which was established in September 1988 under the auspices of Central Medical Advisory Committee; the remit of the committee is to promote clinical efficiency in the health service in Northern Ireland while ensuring that the highest possible standard of clinical practice is maintained.

MEMBERSHIP OF CREST

Professor Gary Love—Chairman
Professor John Bridges
Dr Kate Gillespie
Mr George Humphreys
Dr James Laird
Dr Janet Little
Mr Michael O'Hare
Dr Clive Russell
Dr David Stewart
Dr Oliver Woods
Dr Philip McClements—Convenor

What is a waiting list?

Patients waiting for Health Service diagnosis or treatment can be broken down into two main groups:

1. Patients who have to wait due to unavailability of some health care resource, for example, lack of staff, beds, theatre time or equipment. These patients can be further divided into two groups:

“WAITING LIST” _ People who are waiting and who have not been given a proposed date on which the service will be provided.

“BOOKED” _ People who are waiting but who have been given a date on which the service will be provided.

2. **“PLANNED PATIENTS”** _ Patients who are waiting for social or clinical reasons until a more appropriate date.

Clinical interest in the management of waiting lists is mainly concerned with the **“WAITING LIST”** and **“BOOKED”** categories as in these cases delay is due to at least one element of the resources required not being available immediately whereas **“PLANNED PATIENTS”** are being provided with a service which is appropriate to their needs.

Why have a waiting list?

A properly managed waiting list is important for both patients and their doctors.

For patients, waiting lists should ensure that they are treated in terms of clinical priority and that low priority patients are treated fairly.

For doctors, waiting lists should enable them to schedule their work appropriately and to use resources in the most effective way. The waiting list should also assist them to assess the pressures on their service.

Ways to keep a waiting list?

A survey within Northern Ireland revealed that waiting lists are kept in a number of different ways including computer held systems, manual index systems and diary based systems and various mixtures of these. ([See Appendix I](#)). Wide ranges of people are also involved in their management including medical, nursing, secretarial and medical records staff. In a significant minority of cases there was minimal input into waiting list management by medical staff.

Such variations in practice suggest that at present it is unlikely that waiting lists are being managed optimally in every case, in the best interests of patients.

The following are important criteria for an effective waiting list system.

1. There should be a reliable method for allocating clinical urgency.
2. The system should allow patients to be treated in a fair way in relation to their clinical needs and the length of time they have been waiting.
3. The list should be easily reviewed.

Recommendations for a better waiting list management

General

1. Each consultant should be personally responsible for his/her waiting list and should monitor it regularly.
2. Each clinician should develop a short statement defining categories of clinical urgency for outpatients and inpatients.

e.g. A—very urgent
 B—urgent
 C—soon
 D—non-urgent

3. A doctor should be responsible for placing each patient in one of the waiting list categories of urgency.
4. A clear procedure for taking patients from the list should be developed in relation to their clinical urgency and their time on the list.
5. At the time of being placed on the list patients should be placed into one of these categories.

“WAITING LIST” _ people who are waiting and who have not been given a proposed date on which the service will be provided.

“BOOKED” _ people who are waiting but who have been given a date on which the service will be provided.

“PLANNED” _ patients who are waiting for social or clinical reasons until a more appropriate date.

6. All junior medical and non-medical staff involved in waiting list management should clearly understand the categories of urgency and the procedures to be followed.

7. Information about waiting lists should be shared with hospital colleagues and GPs. Medical representatives on management groups should be made aware of developing waiting list problems.
8. A procedure for reviewing patients who are on the waiting list for a prolonged period should be developed with medical records staff; for example, after 1 year's delay patients should be contacted to see if they still require the procedure.
9. Consultants within a firm should discuss the advantages and disadvantages of common lists.
10. All consultants should consider the possible benefits of computer assisted lists to help them with handling and reviewing their waiting lists. Individual lists can be held on the Patient Administration System which is already in operation in many hospitals. This system is sufficiently flexible to enable each consultant to use his/her own urgency categorisation.

IN HANDLING WAITING LISTS CLINICAL URGENCY SHOULD BE PARAMOUNT BUT IT IS IMPORTANT TO BE FAIR!

In-patients

1. Consider how case mix for operating lists should be agreed. Don't leave all the uninteresting cases to grow on your list.
2. Consider having a separate list for day surgery patients.
3. Make sure that your waiting list information contains patient phone numbers so that patients can be brought in at short notice.
4. Consider an assessment system to make sure patients are fit for surgery before they are brought in. Patients who have waited for a long period may have deteriorated. A pre-admission assessment clinic is run by some clinicians and may mean patients can be admitted for a shorter period pre-operation.
5. Make sure that patients are asked to confirm their acceptance when they are offered admission. If they do not confirm within a specified time their place should be filled by another waiting list patient. Action should be taken to check that the individual who failed to reply still requires admission.

List of basic information to be held on waiting list patients

In-patients and day cases

1. Name
2. Address
3. Phone number
4. Date of birth
5. Referring doctor
6. Doctor who placed patient on list
7. Date placed on list
8. Diagnosis
9. Procedure
10. Urgency category allocated
11. Category of patient
 - waiting list - no appointment
 - booked-diary - date of admission
 - planned-social - or clinical reason for deferred admission
12. Action to be taken pre-operation-e.g.,
 1. refer to assessment clinic
 2. check if still requires admission
13. Details of any deferred admissions by
 1. Doctor
 2. Patient
 - including date of deferral and reason.

Out-patients

1. Name
2. Address
3. Phone number
4. Date of birth
5. Referring doctor
6. Date referral received
7. Diagnosis by referring doctor
8. Urgency category allocated
9. Appointment given yes/no (with date if applicable)
10. Action taken—request for investigations pre-visit
11. Follow-up details if waiting list is long—check if patient still needs appointment pre-visit
12. Dates of non-attendance and action taken.

Appendix 1 - Waiting list management in N. Ireland.

1. Survey of Clinicians

- 1.1 A survey was carried out of all surgeons and physicians in specialities where significant waiting lists exist. The aims of the survey were to:
- 1.1.1 identify the methods whereby waiting lists are held and managed
 - 1.1.2 identify why particular waiting list systems are used
 - 1.1.3 discover if clinicians had received any training in waiting list management
 - 1.1.4 discover if any information on waiting lists is circulated to other members of the profession
- 1.2 199 questionnaires were distributed and 153 replies have been received, a response rate of 77%. The response rate by specialty is shown in the following table.

Specialty	Response Rate
General Surgery	83%
ENT surgery	82%
Orthopaedic Surgery	74%
Gynaecology	76%
Ophthalmology	69%
Oral Surgical Specialties	53%
Other Surgical Specialties	95%
Cardiology	69%

1.3 Results

1.3.1 Location and storage of waiting lists

Waiting lists are held in a wide range of locations and in a number of forms. Most out-patient lists (51%) are held in Medical Records while most in-patient lists (51%) are held in the clinical secretary's office. More than one third of out-patient lists and about a quarter of in-patient lists are held on computer. Other forms of storage include diaries, file systems and notebooks.

1.3.2 **Management of waiting lists.**

A small but significant proportion of waiting lists is claimed to be managed entirely chronologically (17% of outpatient and 7% of in-patient waiting lists) although the vast majority take into account clinical urgency.

48% of all respondents indicated that the outpatient waiting list was managed by non-medical staff while for in-patients the figure was much lower at 17%.

While the vast majority of respondents indicated a medical input into the monitoring of waiting lists (75% of outpatient and 91% of in-patient waiting lists), a significant minority reported that there was no monitoring or that non-medical staff undertook this task.

51% of respondents reported that “booked” patients i.e. those who are given a specific date for admission, are included in the waiting list figures.

41% of respondents reported that they held a separate waiting list for day cases.

49% of respondents indicated that they had developed their own system for managing their in-patient waiting list while 40% had continued the existing system.

1.3.3 **Information and Training**

53% of respondents reported that waiting list information is presented regularly to colleagues in the same specialty but this figure dropped to 36% for General Practitioners and 35% for other hospital colleagues.

Only 7% of respondents had received any training in waiting list management.

2. **Survey of Medical Records Officers**

Group/Senior Record Officers at fifteen locations throughout N. Ireland were interviewed by one of the authors (CMcC). The interviews were carried out on a semi-structured basis. This survey has highlighted a number of issues regarding waiting list management.

- 2.1 A range of systems is in operation differing between and within hospitals and also between and within specialties.
- 2.2 Some confusion exists about the nature of the information to be collected on waiting lists, for example, between "waiting list" patients where no date of proposed admission has been given and "booked" patients where a proposed date has been given. On a few sites the Korner recommendations have not yet been implemented.
- 2.3 In a small number of cases it would appear that outpatients are being allocated entirely chronologically without any input from hospital medical staff
- 2.4 It would appear that where computer systems are up and running, manual systems are often running concurrently, which is increasing workload.
- 2.5 In some facilities (7 out of 15) separate waiting lists are kept for day cases.
- 2.6 In most facilities (10 out of 15) lists are held of patients willing to be admitted at short notice.
- 2.7 The dissemination of relevant information on waiting lists varies widely. In some facilities information is presented regularly to the hospital consultants and local General Practitioners as well as to Unit Management Groups.
- 2.8 There is no conformity between procedures for dealing with non-attenders, which may influence waiting list numbers and waiting times. In the case of elective admissions, some hospitals ask patients to confirm that they intend to take up the offered admission. With one exception in the units visited there is no sanction taken if patients fail to confirm.
In the case of outpatient attendances, patients are usually asked to contact the hospital if they are unable to attend. They are not asked to confirm that they will take up an offered appointment.
- 2.9 "Weeding" of waiting lists is seen as worthwhile but generally undertaken sporadically.
- 2.10 Many hospitals outside Belfast use lists provided by the local Registrar of Deaths to remove, from the waiting list, the names of patients who have died.
- 2.11 It was generally felt that computerisation would improve waiting list management.
- 2.12 None of the medical records staff interviewed had had any specific training regarding waiting list management.

Mr G Humphreys
Dr D Stewart
Dr C McCaugherty

June 1989